

**Circumstances surrounding the death of
a man at HMP Prescoed on
in October 2007**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

January 2009

This is the report into the death of a life sentenced prisoner at HMP Prescoed. The man died on 12 October 2007. He was aged 53. I would like to offer my sincere condolences to the man's family and friends for their sad loss.

My colleague conducted the investigation. In addition, the Healthcare Inspectorate Wales, conducted a clinical review into the man's medical care in custody. I would like to thank the Governor of HMP Prescoed and his staff for their assistance during my enquiries.

During the man's time at Prescoed, he had little contact with the medical team and was considered to be fit and well. He had been working in the community prior to his death and was looking forward to going on home leave. The man's death was sudden and unforeseen and therefore came as a shock to all those who were close to him.

The outcome of the post mortem was not published until results from toxicology tests were received, but early indications were that the cause of the man's death was coronary thrombosis. The toxicology tests then revealed that the man had heroin in his system. This led to a police investigation, which was concluded in September 2008. No charges were brought as a result of the police investigation and the man's death is still believed to have been from natural causes.

The police enquiries contributed to the delay in concluding my investigation and I would like to apologise to the man's family for this.

I make three recommendations. These are in relation to searching, drug testing and record keeping. In addition, I also acknowledge the positive way in which the prison supported the man's family after his death.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man was sentenced to life imprisonment with a tariff of 20 years in May 1983. In 2005, he transferred for the second time during his sentence to open conditions, this time at HMP Prescoed. The man initially had some setbacks at Prescoed. He failed a mandatory drugs test and was transferred for a short period to the closed conditions of nearby HMP Usk. After a period of assessment, he returned to Prescoed and began to progress. Throughout this period, he only had minor medical concerns and very little contact with the healthcare team. The man progressed to second stage resettlement, which enabled him to undertake paid employment in the local community. It also meant that he was moved into a 'half way' house located just outside the prison. On 11 October 2007, the man attended his job at a factory in Caldicott, Herefordshire as usual. During the day, his friends said that he appeared his usual self and made no mention of feeling unwell. They also said that when they went to bed he was lying on the sofa in his room watching television.

At approximately 6.30am on 12 October, another prisoner who lived in the house, knocked on the man's door to see if he was ready for work. There was no reply so he went into the room and saw that the man was lying on the sofa with his legs up over its arm. The other prisoner knocked the man's leg and said, "get up" but got no response. Believing the man to be fast asleep, the other prisoner left the room to brush his teeth before returning some three or four minutes later. When he returned, the man was still lying there and did not respond to his touch, the other prisoner summoned help from prison staff.

An officer went straight to the house after being alerted by the other prisoner and saw the man lying across his sofa. The officer checked for his pulse, but the man appeared to be dead. She left the house and went to the gate area a short distance away to inform the night orderly officer, who immediately contacted the emergency services. The officer returned to the house with a colleague, who also checked the man's pulse.

At 7.00am, a senior officer came on duty and was told about the man by the night orderly officer. The senior officer then went over to the house to check on the man himself before updating the ambulance crew by telephone. The senior officer told the ambulance staff that, in his opinion, rigor mortis was present. The ambulance crew arrived at 7.20am, and pronounced that the man was dead. A police surgeon later confirmed the death.

Due to the distance from the family home, the prison asked the police to break the news to the man's next of kin. This was quickly followed up with a visit by the prison's Family Liaison Officer who provided regular contact with information and support, arranged an opportunity for the family to visit the prison, and provided active assistance with the funeral arrangements.

Following the man's death, the police launched an investigation after the toxicology tests showed that he had heroin in his system. The police interviewed both prison staff and prisoners. Their investigation concluded in September 2008 and no charges were brought as a result.

I make three recommendations relating to searching, drug testing and record keeping.

THE INVESTIGATION PROCESS

1. My colleague conducted the investigation. The prison provided my investigator with the man's prison records, including his medical history. Notices were displayed to staff and prisoners, informing them of the investigation process and giving them the opportunity to speak to my investigator. No responses were received.
2. I commissioned a clinical review into the medical care the man had received at Prescoed. The Healthcare Inspectorate of Wales conducted this review and her report is attached as an annex. I am most grateful to her.
3. The man had recently been reconciled with his wife. My investigator and one of my Family Liaison Officers, visited the man's wife on Wednesday 14 November 2007. The man's wife was having great difficulty in understanding how he could have died so suddenly. She said that she had visited him in July when he had seemed to be in excellent health. There were several recent photographs of the man around the house, looking well and in good spirits. The man's wife asked for clarification of a number of issues, which I hope, have been addressed in this report and the clinical review. The family had no concerns with the treatment the man had received at Prescoed. They visited the establishment after his death, meeting his friends and staff who worked closely with him. The man's wife appreciated this.
4. My investigator visited HMP Prescoed on 20 November to interview members of staff who had been present on the morning of the man's death. Transcripts of the interviews are annexed to this report.
5. My investigator wrote to HM Coroner to inform him of the nature and scope of the investigation. A copy of this report will be sent to the Coroner to assist with his enquiries. The initial post mortem concluded that the man had died as a result of heart failure.
6. The Coroner's officer contacted my investigator again on 25 February 2008, with further information following the results of the toxicology report. This showed that there were significant amounts of heroin in the man's system at the time of his death. Because of this, a police investigation was conducted. This concluded in September 2008 without any charges being brought. During the police investigation, copies of further statements were made available to my investigator. The cause of death recorded in the initial post mortem remains unaltered.

HMP PRESCOED

1. HMP Prescoed is a category D prison for adult men, located just outside the town of Usk in South Wales. It is linked to HMP Usk, which is around three miles away. Originally opened in 1939 as an open borstal, Prescoed went through a number of roles over the years before finally being used in its current capacity in 2004.
2. The residential units at Prescoed are mostly made up of single occupancy rooms, with around ten that are double occupancy. All prisoners have keys to their rooms as is the case with most open establishments. As part of the prisoner's resettlement programme there is another residential unit known as the 'halfway house'. It is made up of two semi-detached houses with six single and two double bedrooms. Each house also has a lounge, kitchen and bathroom facilities. The purpose of the houses is to provide longer-term prisoners with the opportunity to experience life outside prison and regain skills they may have lost, whilst retaining the support of the prison community. Prisoners located in the houses are responsible for reporting to the gate in the mornings and staff complete roll checks at 6.00am and last thing at night. There are no staff permanently based in the houses.
3. Healthcare provision at Prescoed is similar to that in the wider community. A nurse is available from 7.30am until 9.00am Monday to Friday in the healthcare centre. The nurse treats most cases, but where this is not possible the individual is referred to the doctor who attends three days per week. A number of healthcare facilities are available to prisoners at Prescoed ranging from dental, optometric and chiropody services to various chronic disease management clinics.
4. An announced inspection at Usk and Prescoed by HM Chief Inspector of Prisons, Ms Anne Owers, was carried out in April 2005. Ms Owers concluded:

"We have identified some areas for development at both prisons, and the resettlement impetus at Prescoed needs to be maintained. However, there was no sense, in either establishment, of a prison that was resting on its laurels. On the contrary, managers and staff were aware that maintaining standards of excellence requires continual effort, and welcomed our proposals for further improvement."
5. At Usk and Prescoed there has been one previous death from natural causes that I have investigated. There do not appear to be any similarities with this investigation.
6. The most recent Independent Monitoring Board (IMB) report said of Prescoed:

"The atmosphere at Prescoed is slightly different to that of Usk because of the nature of an open prison and of the type of prisoner who is there, the establishment also has a calm atmosphere, but that is not to say it is not busy. The staff engaged on resettlement are to be applauded for their efforts in finding work placements."

KEY FINDINGS

Events leading up to the man's death

7. Following his remand at HMP Brixton in November 1982, the man was sentenced to life imprisonment at the Central Criminal Court, on 18 May 1983. He was given a tariff (minimum time to possible release on licence) of 20 years. During his initial health screenings on his arrival into custody, no concerns were highlighted.
8. Later in May 1983, the man transferred to HMP Wormwood Scrubs to begin his life sentence. There, he began to get involved in offence-related work. During his time at Wormwood Scrubs, he settled into the regime well and generally kept himself to himself. He had no significant contact with healthcare.
9. The man moved around the prison system several times. Generally, these were progressive moves to assist him in meeting offending behaviour targets and working towards eventually gaining release on licence.
10. In March 2003, the man was on resettlement leave from HMP Leyhill (when a prisoner is allowed to go home for a defined period, usually up to a week) and he stayed at a hostel. Unfortunately, contrary to his licence conditions, the man consumed alcohol and returned to the hostel intoxicated. Consequently, he was returned to closed conditions at HMP Norwich. This was a backward step. The man remained at Norwich until March 2004 when he transferred to HMP Ranby to continue his offending behaviour work. Throughout these periods, the man had no particular health issues.
11. The Parole Board recognised the man's progress in January 2005 by recommending him for open conditions. He then transferred to HMP Prescoed in April 2005.
12. On his arrival at Prescoed, no significant health issues were raised and the man had little contact with the medical services while he was there. His progress at Prescoed was not without setbacks. The man failed routine drug tests and was moved back to closed conditions at HMP Usk whilst he was reassessed. However, he was subsequently allowed to return to Prescoed and then progressed quite quickly to stage two resettlement (community-based paid employment and accommodation in the halfway house).
13. On Thursday 11 October 2007 the man went to his job at a factory in Caldicott, with another prisoner. The man's normal shift hours were 8.00am until 5.00pm. The other prisoner said that when he saw the man during the course of the day he was laughing with work colleagues and appeared normal.
14. The other prisoner said on his return to the prison at around 6.00pm, the man made himself an evening meal and, after eating it, retired to his room. At around 7.40pm, the other prisoner went to the man's room and talked to him briefly before going to his own room.

15. At approximately 6.30am the next morning (12 October), the other prisoner knocked on the man's door to see if he was ready for work. There was no reply so the prisoner went into the room and saw the man lying on the sofa with his legs up over the arm. He knocked the man's leg and said, "get up" but there was no response. Believing the man to be fast asleep, the prisoner left the room to brush his teeth before returning to the man's room some three or four minutes later. The man was still in the same position so the other prisoner pushed his right forearm. He immediately felt that something was wrong and feared that the man had "passed on". The prisoner therefore left the house to summon help.
16. At approximately 6.45am, after being informed by the other prisoner that he thought the man had died, the officer went to the house. On entering the man's room, the officer switched on the light and saw the man lying in the position described by the other prisoner. His arms were folded and his eyes appeared to be half open. The television was also on. The officer called to the man and shook his leg. She checked for a pulse on the man's neck, but could not find one and his skin felt very cold. The officer then went to the gatehouse a short distance away. She informed the night orderly officer that she believed the man was dead and that they required an ambulance. It was called immediately.
17. On her way back to the house, the officer met a second officer who had just started duty. She informed him that there was a problem with the man and he accompanied her to the house. The second officer also checked for a pulse, and then attempted to move one of the man's arms but it appeared stiff. Both officers left the room but the second officer remained in the house to ensure that nobody went inside. The officer returned to the gatehouse to update the Orderly Officer.
18. At around 7.00am, a senior officer came on duty and was briefed as to the man's condition. The senior officer went to the house, verified that in his opinion rigor mortis had set in, and then passed the information to the Ambulance Service by telephone. The ambulance arrived at the prison at 7.20am. The paramedics pronounced the man dead and the police surgeon later confirmed the death.

Events following the man's death

19. The prison appointed a family liaison officer. Due to the man's wife living some distance, the prison asked the local police to inform her of his death and to tell her that the prison family liaison officer would visit later that day.
20. The prison family liaison officer, together with the prison chaplain, arrived at the man's wife's house at 7.30pm. They spent time with the man's wife answering questions, as well as giving advice and guidance. They agreed to return the following morning, (13 October), to accompany her to tell her daughter of her father's death. After making the visit, they left to return to Prescoed at 1.40pm.

21. The prison family liaison officer kept in regular contact with the man's wife, informing her of anything that arose in connection with his death, as well as answering further queries. She also arranged for his wife and a friend to visit Prescoed on 24 October. The prison made all the necessary travel arrangements and met the costs. The man's wife spent the day talking with his friends as well as viewing the prison grounds and the man's room. At the end of the visit, the prison family liaison officer and a principal officer drove the man's wife back to her home, taking his property with them.
22. The prison arranged for the chaplain to conduct the funeral service, and offered assistance with funeral costs. The prison also sent a wreath on behalf of staff and prisoners. At the request of the man's wife, the principal officer and the other prisoner acted as pallbearers at the funeral, which was held on 2 November. The Governor of Prescoed and the prison family liaison officer also attended.

ISSUES

Searching Procedures

23. Following the police investigation concerns were raised regarding the procedures for searching prisoners returning to the prison after attending work in the local community. Information supplied to the police indicated that illicit items such as drugs were finding their way into the prison. Although systems were in place for searching prisoners on their return from work, it was apparent that these were not entirely effective.
24. My investigator contacted Prescoed after the police told him of their findings to alert the prison to the potential problems that they had. The Governor was grateful for the information and said that the prison would act on it straight away. My investigator also asked a Governor whether the searching at Prescoed had been improved since the man's death. The Governor said that, although he had only arrived at the prison in recent months, he was aware that searching procedures had been "tightened up". He went on to say that all vehicles entering the prison are now routinely searched and all prisoners returning from outside work are subject to a rub down search and a percentage are randomly strip searched.
25. I am pleased to learn that Prescoed is taking steps to try to address the issue of illicit and harmful items being brought into the prison. I also acknowledge that this is an ongoing problem across the wider open prison estate. However, I make the following recommendation in relation to searching:

The Governor should ensure that the Searching Policy at Prescoed is reviewed and takes account of the concerns raised by the police following their investigation.

Drug Testing

26. My investigator was told that the prisoners located in the 'halfway house' are subject to the same random drug testing as those prisoners located in the remainder of the prison. Given the potential for these prisoners to have greater access to drugs and the limited staff supervision in the 'halfway house', these procedures may not be sufficient. I therefore make the following recommendation:

The Governor should review the Drug Strategy Policy at Prescoed with a view to increasing the frequency of drug tests for prisoners located in the 'halfway house'.

Family Liaison

27. The support and advice provided to the man's family was of a particularly high standard. The prison went beyond what would normally be expected in addressing the family's concerns appropriately and quickly. The family greatly appreciated the visit to the prison and the financial contribution towards the funeral.
28. It is standard practice for the prison to ask the local police to inform the next of kin of deaths when they live a long distance away. However, the prison also arranged for their own staff to attend the family home quickly and this ensured that the family were able to get immediate answers to their questions and much needed support.

I commend the staff at Prescoed for the welcoming, professional and courteous way in which they supported the man's family and for their efforts in addressing their needs.

Medical Care

29. The Healthcare Inspectorate of Wales, conducted the clinical review into the man's care while in prison custody. A copy of her report is attached in full as an annex.
30. Apart from minor ailments that were quickly diagnosed and treated, it would appear that the man had little contact with the healthcare services in custody. The clinical reviewer concludes that the quality of primary care given to the man while he was in prison was good. However, she finds that while records appeared to be complete, they were filed in the wrong order. The clinical reviewer makes the following recommendation which I endorse:

Healthcare staff should take steps to ensure they adhere to the guidance on records and record keeping issued variously by the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain.

Conclusion

31. The man's death came at a time when he seemingly was making good progress towards release on life licence and had a settled personal life. It was clearly a shock for his family and friends given that he had such little contact with healthcare during his entire time in custody. It is hoped that the inquest will be able to assist them further in explaining why a relatively young and seemingly healthy man died so suddenly.

Response to Draft Report

32. At the time of issuing my final report, the Prison Service had not responded to the draft. The man's family informed my Family Liaison Officer, that they had no issues or comments to make on the draft report and were happy with the final being issued.

RECOMMENDATIONS AND GOOD PRACTICE

- 1. The Governor should ensure that the Searching Policy at Prescoed is reviewed and takes account of the concerns raised by the police following their investigation.**
- 2. The Governor should review the Drug Strategy Policy at Prescoed with a view to increasing the frequency of drug tests for prisoners located in the 'halfway house'.**
- 3. Healthcare staff should take steps to ensure they adhere to the guidance on records and record keeping issued variously by the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain.**

GOOD PRACTICE

- 1. I commend the staff at Prescoed for the welcoming, professional and courteous way in which they dealt with the man's family and for their efforts in addressing their needs.**